

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, end in any event within 72 hours after death.

M

I

7837
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07829

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hilary Middle John Last Balling				4. DATE OF DEATH Month 7 Day 1 Year 19 61			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-7-1912	
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY House Painting			
11. BIRTHPLACE (State or foreign country) Del.				12. MOTHER'S MAIDEN NAME Louise Nurnberg			
13. FATHER'S NAME John W. Balling				14. MOTHER'S MAIDEN NAME Louise Nurnberg			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. 217-05-3869			
17. INFORMANT Mrs. Marie P. Balling, 220 W. Main St.				Address Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) 420.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 3, 1961				22b. DATE THEREOF July 3, 1961			
22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery				22d. LOCATION (City, town, or country) (State) Wilmington, Del.			
23. FUNERAL DIRECTOR Ralph E. Hicks, Elkton, Md.				24a. REC'D BY REGISTRAR 10 61			
24b. REGISTRAR'S SIGNATURE Charles S. Knauss				DATE 7-2-61			

M

Coall

Id.

Coall

Elston

D.O.A.

Elston

Union Hospital

220 W. Main

Henry

John

Belling

2-7-1912

Painter

House Painting

Del.

U.S.A.

John W. Belling

Louis Newberg

Elston, Md.

217-02-3889

Mrs. Marie P. Belling, 220 W. Main St.

Route Coronary Connection

R.C. Johnson

Living 8th, Md.

7-3-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7838
CERTIFICATE OF DEATH
07830

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EIKTON</u> c. LENGTH OF STAY IN lb <u>25 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>De VUE HAVEN CONVALESCENT HOME</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u> d. STREET ADDRESS <u>803 REVOLUTION ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>P. HOEBE</u>		First Middle Last		4. DATE OF DEATH <u>7 30 1961</u>		Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/25/1884</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN ROBINSON</u>		14. MOTHER'S MAIDEN NAME <u>Ida May Urban Hotstetter</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>ADA B. WALLETT - HAVER DE GRACE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTION LUNGS & VISCERA</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CORONARY ARTERIOSCLEROSIS</u> (c) <u>PNEUMONITIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u> <u>YEARS.</u> <u>7 DAYS.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/15/61</u> , 19 <u>61</u> , to <u>7/30</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/30</u> , 19 <u>61</u> , and that death occurred at <u>5:00</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>J. Randall Ross</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/30/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. RANDALL ROSS, M.D.</u>				22d. ADDRESS <u>EIKTON, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/1/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		23d. LOCATION (City, town or county) (State) <u>Haver de Grace Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Cunningham Son</u> ADDRESS <u>Haver de Grace, Md.</u>				25a. REC'D BY REGISTRAR <u>AUG 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7839

CERTIFICATE OF DEATH

Reg. Dist. No.

07831

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle BAWULAK Last		4. DATE OF DEATH July 20, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1894
9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME No Info.		14. MOTHER'S MAIDEN NAME No Info.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
INFORMANT Panko Bawulak		Address Chesapeake City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Cardiovascular disease (b) Diabetes Mellitus (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 days within	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 17, 1961, to July 20, 1961, that I last saw the deceased alive on July 20, 1961, and that death occurred at 10:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) CHESAPEAKE CITY	
ACTUAL SIGNATURE HENRY V. DAVIS M.D.		DATE SIGNED 7/24/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/1961	
22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception		22d. LOCATION (City, town, or county) (State) Nr. Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR DATE JUL 26 '61	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

Reg. Dist. No. 07832

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>New Castle</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		d. STREET ADDRESS <u>5 S. Cox St.</u> 46X-3	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clifton Thomas Beck</u>		4. DATE OF DEATH Month Day Year <u>July 15 th 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 25, 1884</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Beck</u>		14. MOTHER'S MAIDEN NAME <u>Alice Morries</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Mrs. Clifton Beck</u> Address <u>Middletown, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic nephritis</u> DUE TO (c) <u>Heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>6 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 30, 1961</u> to <u>July 15, 1961</u> , that I last saw the deceased alive on <u>July 15, 1961</u> , and that death occurred at <u>10:49 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry J. Dan</u> M.D.		DATE SIGNED <u>7/15/61</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/18/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Massey Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Massey Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Louis Daniels - Middletown, Delaware</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 21 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1910

1910

(M)



7841

CERTIFICATE OF DEATH

Reg. Dist. No. 07833

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sassafras.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 14 X - 2			
3. NAME OF DECEASED (Type or print) First Pearl Middle Blackiston Last Blackiston				4. DATE OF DEATH Month July Day 26 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March, 14, 1884	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Chestertown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W.L.Faulkner				14. MOTHER'S MAIDEN NAME H.C.Collins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. Informant		Address Mrs. Pearl Jarrell, 2520 West St. Wilm. Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC BRAIN SYNDROME 450.0 DUE TO ARTERIOSESOSIS GENERAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from July 24, 1961 to July 26, 1961 that I last saw the deceased alive on July 26, 1961 , and that death occurred at 2:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE Henry V. Davis M.D.				PHYSICIAN'S NAME (Type) HENRY V. DAVIS M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July, 29, 1961		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) Chestertown, Kent Co; Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Millington, Md.				24a. REC'D BY REGISTRAR DATE JUL 31 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

225

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7842

CERTIFICATE OF DEATH

Reg. Dist. No. 07834

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u>				c. LENGTH OF STAY IN 1b <u>3 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MORGAN NURSING HOME</u>				e. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>ELIZABETH</u> Last <u>BOYLES</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>22</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 25 1879</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>HENRY W. TAYLOR</u>				14. MOTHER'S MAIDEN NAME <u>LETITIA KNOTTS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
INFORMANT <u>WM. RAY BOYLES</u>				Address <u>WARWICK MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Hemiplegia</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>C.V. Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May 22</u> , 19 <u>61</u> , to <u>July 22</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 22</u> , 19 <u>61</u> , and that death occurred at <u>12:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V. Davis MD.</u> M.D.				DATE SIGNED <u>7/22/61</u>			
PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS MD.</u>				ADDRESS (Street, city or town, state) <u>CHESAPEAKE CITY MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/25/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WARWICK CEMETARY</u>		22d. LOCATION (City, town, or county) (State) <u>WARWICK MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>				ADDRESS <u>ELKTON 17941490</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 26 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clifton S. Thomas</u>			

(M)

(I)

0

1

1000

NEW YORK

1000

(10)

NEW YORK

NEW YORK

NEW YORK



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7843 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0785

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN lb few hours		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Harford		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood Bel Air - Rural		d. STREET ADDRESS Army Chemical Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alfred		First Augustus		Middle Brooks		Last Brooks		4. DATE OF DEATH Month 7		Day 2		Year 19 61			
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-5-1936		9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months 25		Days 25		IF UNDER 24 HRS. Hours 25 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Edward		13. FATHER'S NAME Edward		14. MOTHER'S MAIDEN NAME Blanche Williams											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes		16. SOCIAL SECURITY NO. 218-32-5791		17. INFORMANT Army Records. A Edge wood. Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 929.8 DUE TO Drowned															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)															
DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Wading into deep water													
20c. TIME OF INJURY Month, Day, Year Hour a.m. 7, 39		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ches. Del. Canal		20f. (City or town) Chesapeake City Cecil Md.		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE R.D. Dodson		EXAMINER'S NAME (Type) R.D. Dodson		M.D. Rising Sun, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7-3-61			
22a. BURIAL, CREMATION, or other disposition of remains July 5, 1961		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Clark's Chapel Cem		22d. LOCATION (City, town, or country) Harford Co Md		(State)							
23. FUNERAL DIRECTOR H.S. Bailey		ADDRESS Barling ton Md		24a. REC'D BY REGISTRAR DATE 12 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

MEDICAL CERTIFICATION

STATE OF SOUTH CAROLINA

Castell

Chesapeake City

low hours

Hedgeswood

Md.

Hammonds

Spec. Del. Canal

Army Chemical Center

Blind

Augusta

Brooks

7

2

01

0

1-7-1936

25

Soldier

U.S. Army

Md.

U.S.A.

Edward

Brooks

Blanche Williams

Edward

118-32-721

Army Records, Hedgeswood, Md.

Deceased

7 2 01

Spec. Del. Canal

Chesapeake City Canal Md.

R.C. Dodson

Native Son, Md.

7-3-01

1 FOR STATE HEALTH DEPT.

TO USE: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09004

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY in lb 47 hours		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton, R.D.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital				d. STREET ADDRESS Dogwood Road			
3. NAME OF DECEASED (Type or print) First John Middle H. D. Cameron Last Cameron				4. DATE OF DEATH Month 7 Day 31 Year 19 61			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-48	9. AGE (In years last birthday) 13 yrs.	IF UNDER 1 YEAR Months 13 Days 13	IF UNDER 24 HRS. Hours 13 Min. 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Boy		10b. KIND OF BUSINESS OR INDUSTRY Student		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Cameron			14. MOTHER'S MAIDEN NAME Buelah Smith				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Arthur Cameron, Elkton, R.D. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mutilated right hand Shock perforation of intestines DUE TO (b) perforation of Iliac vessels massive hemorrhage and cerebral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) anoxia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Home made bomb went off							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) Home made bomb went off					
20c. TIME OF INJURY Month, Day, Year 8:50 a.m. 7 29 19 61	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dogwood Road		20f. (City or town) Elkton	(County) Cecil	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-31-61			
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 3, 1961		22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Park		22d. LOCATION (City, town, or country) (State) Elkton Maryland	
23. FUNERAL DIRECTOR Ralph E. Hicks, Elkton, Md.		ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR AUG 14 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

perforation of iliac vessels massive hemorrhage and cerebral
anoxia

inflated right hand shock perforation of intestine

Arthur Cameron, Elton, R.D. No.

Arthur Cameron

School Boy

Student

Mr.

U.S.A.

British 21st

John
C. Cameron

Union Hospital

17 hours

Elton, R.D.

Dogwood Road

Drill

Mr.

Drill

7845

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN 1b 3 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Morgan Nursing Home		d. STREET ADDRESS 14 X-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edna M. Chilcoat		4. DATE OF DEATH Month July 25, 1961 Day 19 Year 19			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/22/84	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME George Gorsuch		14. MOTHER'S MAIDEN NAME Emma Woodward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 12-22-2644		17. INFORMANT Mrs. Charles Gorsuch	
				Address Chestertown, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 332 X DUE TO (b) Cerebral Thrombosis - Left Hemiparesis DUE TO (c) Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH 3 years unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 332 X DUE TO (b) Cerebral Thrombosis - Left Hemiparesis DUE TO (c) Coronary artery disease				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 13, 1961, to July 21, 1961, that (I) (we) lost the deceased alive on July 21, 1961, and that death occurred at 8:00 p.m. from the causes and on the date stated above.					
22a. SIGNATURE Henry V. Davis		22b. PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD		22c. ADDRESS CHESAPEAKE CITY MD	
22d. SIGNATURE Henry V. Davis		22e. PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD		22f. ADDRESS CHESAPEAKE CITY MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 28, 1961		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	
				23d. LOCATION (City, town, or county) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Willis Wells		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE JUL 28 '61	
				25b. REGISTRAR'S SIGNATURE Charles E. Hines	

CERTIFICATE OF DEATH

1842



MAY 1842

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7846

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 Film G290 7/17/61 iwk
CERTIFICATE OF DEATH

Reg. Dist. No. 07837

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bohemia Manor	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS near Chesapeake City	
3. NAME OF DECEASED (Type or print) First Middle Last Sadie M. Congo		4. DATE OF DEATH Month Day Year July 4, 19 61	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1900
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Mercer		14. MOTHER'S MAIDEN NAME Phomie White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address Thomas Congo-Bohemia Manor, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 345X multiple sclerosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 29, 1961, to May 4, 1961, that I last saw the deceased alive on May 4, 1961, and that death occurred at 3:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 7/6/61	
ACTUAL SIGNATURE HENRY V. DAVIS M.D.			
PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD		CHESAPEAKE CITY MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/7/61	
22c. NAME OF CEMETERY OR CREMATORY Bohemia Manor Cem.		22d. LOCATION (City, town, or county) (State) Bohemia Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur P. Bell		ADDRESS 909 Poplar St. Wilmington, Delaware	
24a. REC'D BY REGISTRAR DATE JUL 10 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

OFFICE OF DEATH

2840

WILLIAM J. B. WILSON
CHIEF OF POLICE
CITY OF NEW YORK

(M)



CERTIFICATE OF DEATH

Reg. Dist. No.

07838

7847

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY New Castle			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown R.D. 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 46X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walter Coverdale				4. DATE OF DEATH July 25 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 23, 1878	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Samuel Coverdale				14. MOTHER'S MAIDEN NAME Eliza Carpenter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 221-14-2396			
17. INFORMANT Mrs. W. S. George, Camden, Del.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO (b) HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE DUE TO (c) CHRONIC PROSTATITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 30 DAYS 3 years 5 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1954 , to July 25 1961 , that I last saw the deceased alive on July 25 1961 , and that death occurred at 8:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry U. Davis M.D.				ADDRESS (Street, city or town, state) CHESAPEAKE CITY MD			
DATE SIGNED 7/26/61							
PHYSICIAN'S NAME (Type) HENRY U. DAVIS MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 28, 1961		22c. NAME OF CEMETERY OR CREMATORY Barratt's Chapel		22d. LOCATION (City, town, or county) (State) Frederica, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Nick ADDRESS Elkton, Md.				24a. REC'D BY REGISTRAR AUG 2 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

(M)

1937

1937

Bellevue
New Castle

Bellevue A.D. 1

Nov. 22, 1937

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

1937-1938

1937-1938

1937-1938

1937-1938

1937-1938

1937-1938

1937-1938

1937-1938

1937-1938

1937-1938

1937-1938

1937-1938

1937-1938

1937-1938

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7848

07839

1. PLACE OF DEATH e. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>	
c. LENGTH OF STAY IN TB <u>26 years</u>		d. STREET ADDRESS <u>East Cecil Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>East Cecil Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>M.</u> Last <u>COYLE</u>		4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1874</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>England</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harry Worthington</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>John C. Coyle, North East, Maryland</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure -Valvular Heart Disease</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Cardio- Vascular Renal Disease</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>Arthritis -Spinal</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 12, 1961</u> to <u>July 16, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 13, 1961</u> , and that death occurred at <u> </u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Cantwell</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>H3 Arthur Cantwell M.D.</u>		22d. ADDRESS <u>North East, Maryland</u>	
22b. DATE SIGNED <u>7/18/61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 19, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Immaculate Conception Cemetery, Elkton, Maryland</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicke, Elkton, Md.</u> ADDRESS <u> </u>			
25a. REC'D BY REGISTRAR <u>Aug 1 '61</u> DATE <u> </u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

2072

2072

M

1

Cardiac Failure - Valvular Heart Disease
Cardio-Vascular Renal Disease

Anthrax - spinal

July 18, 1951

Robert L. Smith

Harvard University, U.S.

Robert L. Smith, Boston, Mass.

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7849 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07840

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New Jersey b. COUNTY Salem			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 3 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pennsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital of Cecil County				d. STREET ADDRESS 5th & Castle Heights			
3. NAME OF DECEASED (Type or print) First Middle Last Harry A. Dalbow				4. DATE OF DEATH Month Day Year July 27, 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-29-24	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Work		10b. KIND OF BUSINESS OR INDUSTRY Paper Hanger		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stillwell Dalbow				14. MOTHER'S MAIDEN NAME Christine Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes World War II		16. SOCIAL SECURITY NO. 143-14-2943		17. INFORMANT Mrs. Harry Dalbow		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 5 min.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Rising Sun, Md. DATE SIGNED 7-27-61							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. R. C. Dodson		22a. BURIAL, CREMATION, REMOVAL (Specify) Removal 22b. DATE THEREOF 7-27-61 22c. NAME OF CEMETERY OR CREMATORY LAWNSIDE CEMETERY 22d. LOCATION (City, town, or country) WOODSTOWN, N. J. (State)					
23. FUNERAL DIRECTOR ADDRESS PIPPIN FUNERAL HOME				24a. REC'D BY REGISTRAR DATED JUL 31 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

03860

03860 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH CERTIFICATE

M

John Edward Smith

John Edward Smith

1924

1924

1924

Male

White

1924

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

John Edward Smith

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

7850 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07841

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood Beach c. LENGTH OF STAY IN 1b 48hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Del. b. COUNTY NewCastle c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington d. STREET ADDRESS 1113 W. Third e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Albert Last Dillman, Sr.		4. DATE OF DEATH Month 7 Day 28 Year 19 61	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 6, 1898 9. AGE (In years last birthday) 62 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Welder		10b. KIND OF BUSINESS OR INDUSTRY Welding con.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Dillman		14. MOTHER'S MAIDEN NAME H. Scarborough	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) no		16. SOCIAL SECURITY NO. 221-10-9138	
17. INFORMANT Mrs. John A. Dillman		Address Wilmington, Del. 1112 W. Third St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting Aneurysm of aorta arch 451X Conditions, if any, which gave rise to immediate cause (b) (c) stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rising Sun, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 8/1/61	
22c. NAME OF CEMETERY OR CREMATORY Gracelawn Abbey		22d. LOCATION (City, town, or country) (State) Farnhurst, Delaware	
23. FUNERAL DIRECTOR Albert J. McGreery ADDRESS per q. m. w. Wilmington, Delaware		24a. REC'D BY REGISTRAR AUG 4 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

DATE SIGNED
7-29-61

1
FIVE FIVE
NINE FIVE

1901

Del.

Newcastle

Hollywood Beach

Del.

Wilmington

1113 W. Third

John

Albert

William, Sr.

7

28

01

M

N

Aug. 1, 1900

02

Patented Welder

Welding con.

Md.

U.S.A.

General William

H. Scarborough

no

221-10-2138

Mrs. John A. William 1113 W. Third St.

Wilmington, Del.

Disappearing Anonymous note and

R. C. Dobson

Malby St., Md.

x

7-22-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07842

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 38yrs.2mo.11days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Pennsylvania b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olanta d. STREET ADDRESS R.D. #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WALTER S. ENGLISH		4. DATE OF DEATH Month Day Year July 5 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-15-86
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fraffius English		14. MOTHER'S MAIDEN NAME Elizabeth Woodling	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arrhythmia ventricular 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease (a), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XXXXXX attended the deceased from April 24, 1923, to July 5, 1961, and that death occurred at 11:20pm from the causes and on the date stated above.			
22a. SIGNATURE A.L. Mooney M.D.		22b. DATE SIGNED 7-6-61	
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY Asst.Clinical Pathologist, V.A.Hospital, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 7/7/1961		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Fairview		23d. LOCATION (City, town or county) (State) Clearfield County, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		25a. REC'D BY REGISTRAR 11:11 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Kraus			

14

- 21 -

2095:41

1237

2214

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7853 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07844											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North East River						d. STREET ADDRESS Port Deposit				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First PAUL Middle ESETEL Last FULLER			4. DATE OF DEATH Month July Day 23 Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/19/1909		9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 51 Days 19 Hours 19 Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Saw-Mill		11. BIRTHPLACE (State or foreign-country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Fuller						14. MOTHER'S MAIDEN NAME Julia Meadows					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 177-10-9691		17. INFORMANT Eula May Fuller Address Port Deposit, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Acute alcoholism											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found drowned (Was swimming)							
20c. TIME OF INJURY Hour 4:35 p.m. Month, Day, Year 7/23 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) North East River		20f. (City or town) Cecil		20g. (County) Md.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Peter W. Rieckert				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 7/24/61			
EXAMINER'S NAME (Type) Peter W. Rieckert, M.D.				M.D. ASSISTANT MEDICAL EXAMINER Associate Pathologist							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/ 27/1961		22c. NAME OF CEMETERY OR CREMATORY Hopewell Cem.		22d. LOCATION (City, town, or country) Port Deposit		22e. (State) Md.	
23. FUNERAL DIRECTOR Cormon E. McMullen						ADDRESS Rising Sun, Md.		24a. REC'D BY REGISTRAR JUL 27 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

WITNESSES
MAY 1961

(M)

(1)

Labort

Saw-Mill

Virginia

U.S.A.

and Fuller

Julia Meadows

no

177-10-9991 Julia May Fuller

Port Deposit, Md.

7/27/1961 Hopewell Cem.

Port Deposit

Rising Sun, Md.

DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
M
096
7854
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
07845

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Chesapeake City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Morgan Nursing Home</u>		d. STREET ADDRESS <u>Box 217, R. D 1</u>	
3. NAME OF DECEASED (Type or print) <u>EDWIN</u> <u>RUTHVIN</u> <u>GILL</u>		4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1868</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Painting</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Bangor, Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Alexander Gill</u>		14. MOTHER'S MAIDEN NAME <u>Matha Elison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. A. Hallier Johnson, Chesapeake City</u>		Address <u>R. D. 1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>OLD AGE</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this physician) attended the deceased from <u>June 15, 1961</u> to <u>July 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 5, 1961</u> , and that death occurred at <u>9:00</u> M, from the causes and on the date stated above.			
22e. SIGNATURE <u>Henry V. Davis MD</u>		22b. DATE SIGNED <u>7/6/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS MD</u>		22d. ADDRESS <u>CHESAPEAKE CITY MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/10/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pine Hill Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Dover, New Hampshire</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Nickerson</u>		25e. REC'D BY REGISTRAR DATE <u>JUL 18 '61</u>	
ADDRESS <u>Baltimore, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

1944

1944

M

1

Robert C. Mitchell

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07846

7855

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY in 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point d. STREET ADDRESS 1173 Avenue D. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First DAVID Middle MARKLEY Last GORDON			4. DATE OF DEATH Month July Day 6 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-2-97	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 6 Days 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Refrigeration Mechanic US Govt.			11. BIRTHPLACE (State or foreign country) Wilmington, Delaware		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John B. Gordon		
14. MOTHER'S MAIDEN NAME Mary Macklem			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW-I		
16. SOCIAL SECURITY NO. 315-03-7382			17. INFORMANT Mrs. D. M. Gordon Address Perry Point, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Ventricular fibrillation. DUE TO 433-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) 2. Arteriosclerotic heart disease. DUE TO (c) Unknown					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval Between Onset and Death 5-10 min.					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R. C. DODSON			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DATE SIGNED 7/6/61			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
Address (Street, city, town, or county) Rising Sun, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-9-1961		22c. NAME OF CEMETERY OR CREMATORY Northeast METH CEM.	
22d. LOCATION (City, town, or country) Northeast, Md.		22e. REGISTRAR'S SIGNATURE CECIL C.			
23. FUNERAL DIRECTOR ADDRESS Mitchell Funeral Home, Havre de Grace, Md.			24a. REC'D BY REGISTRAR DATE JUL 11 '61		
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

M

1

John E. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

Wm. H. Gordon

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7856

CERTIFICATE OF DEATH

Reg. Dist. No. 07847

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural		c. LENGTH OF STAY IN 1b 58 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural		d. STREET ADDRESS Jackson Park Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Park Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Jane StClair		4. DATE OF DEATH Month July Day 20 Year 19 61	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 27, 1883	
9. AGE (In years and birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		12. KIND OF BUSINESS OR INDUSTRY U S N Base	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? U S A	
15. FATHER'S NAME William J. StClair		16. MOTHER'S MAIDEN NAME Anna R. Morrison	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO. 220-14-2094	
19. INFORMANT Clifton Jackson		Address Port Deposit, Md. R D	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage, Left Side 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebro-sclerotic DUE TO (c) Edema INTERVAL BETWEEN ONSET AND DEATH 2 yrs		21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
24a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		25a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
26a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		27a. (City or town) (County) (State)	
28. I certify that I attended the deceased from July 16, 1961 to July 20, 1961 , that I last saw the deceased alive on July 20, 1961 , and that death occurred at 7:15 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED July 21, 1961	
ACTUAL SIGNATURE Clarence I. Benson M.D.		PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D. Port Deposit, Md.	
29a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		29b. DATE THEREOF 7-23-1961	
29c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		29d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
30. FUNERAL DIRECTOR'S SIGNATURE Veera Patterson & Son		ADDRESS Perryville, Md.	
31. REC'D BY REGISTRAR DATE JUL 25 '61		32. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **Part I** may be retained by the hospital or attending physician. **Part II** may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7857

07848

1. PLACE OF DEATH e. COUNTY Cecil <div style="text-align: right;">MARYLAND</div>			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE District of Columbia b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 12yrs6mos8days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital			d. STREET ADDRESS 233 - 34th Street, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First OLIVER Middle G. Last JACKSON			4. DATE OF DEATH Month July Day 13 Year 1961		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 6, 1898	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME LLOYD T. JACKSON			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES! WW-I			14. MOTHER'S MAIDEN NAME ALICE DIGGS		
16. SOCIAL SECURITY NO. UNKNOWN			17. INFORMANT Address Hospital Records, VAH., Perry Point, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARRHYTHMIA, ventricular 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) Unknown					INTERVAL BETWEEN ONSET AND DEATH 15-30 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour 11 e.m. 19 p.m. VA	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) January 5, 1949	20f. (City or town) July 13, 1961	(County) and District of Columbia	
21. I certify that A. L. MOONEY attended the deceased from January 5, 1949 to July 13, 1961 , and that death occurred at 1:20AM from the causes and on the date stated above.					
22a. SIGNATURE A. L. Mooney			22b. DATE SIGNED July 13, 1961		
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.			22d. ADDRESS VAH., Perry Point, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 7/18/1961	23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Ft Myer, Va.
24 FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON			25a. REC'D BY REGISTRAR DATE JUL 19 '61		
ADDRESS Havre De Grace, Md.			25b. REGISTRAR'S SIGNATURE Arthur S. Harris		

(M)

Best

Very late

Veterans Administration of 1941

Active

J. L. L. L.

Also

June 6, 1948

Laboret

Marjanna

LYON, J. L.

WASHINGTON

1-1

Yes

UNKNOWN

Hospital Records, Van, Perry Point, Md.

SPONTANEOUS, ventricular

ARTHRITIS, RHEUMATOID

Unknown

January 2, 1941

July 13, 1941

July 13, 1941

U. S. Army, Van, Perry Point, Md.

Washington National

State of Ohio, Md.

REMOVED 11/11/41

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7858

07849

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 49 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill d. STREET ADDRESS Box 57	
3. NAME OF DECEASED (Type or print) OKEY Layton LEWIS		4. DATE OF DEATH July 24 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1917
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter's Helper		10b. KIND OF BUSINESS OR INDUSTRY R.R. -Carpentering W. Va.	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Romey Lewis (deceased)		14. MOTHER'S MAIDEN NAME Hallie McCoy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-II		16. SOCIAL SECURITY NO. 218-18-8548	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia associated with debilitation 722.0 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Pericarditis & Pleuritis 6-8 weeks (c) Rheumatoid arthritis severe Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that the deceased attended the deceased from June 5, 1961 to July 24, 1961 and that death occurred 3:45 AM from the causes and on the date stated above.			
22a. SIGNATURE A. L. MOONEY M.D.		22b. DATE SIGNED 7-24-61	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, Asst. Clinical Pathologist, VAH, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/26/1961	
23c. NAME OF CEMETERY OR CREMATORY Friendship		23d. LOCATION (City, town or county) (State) Fallston, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE KURTZ FUNERAL HOME, Jarrettsville, Md. <i>Charles C. Kurtz</i>		25a. REC'D BY REGISTRAR JUL 26 '61	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

M

17343

7333

Henry John
60 days
Hospital
Box 57

NAME
DATE
1917

...-...
...
...

...
...

...
...

...

...

...

...

CERTIFICATE OF DEATH

Reg. Dist. No. 07850

7859

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Center St.		d. STREET ADDRESS Center St.	
3. NAME OF DECEASED (Type or print) First Rosie Middle L. Last Mason		4. DATE OF DEATH Month July Day 8 Year 19 61	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1883
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME James Jones		14. MOTHER'S MAIDEN NAME Ellen Amby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Virginia Mason, Port Deposit, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 174X Carcinoma Uterus - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Hypertension - Chr Nephritis -			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 5, 1961 to July 7, 1961 , that I last saw the deceased alive on July 7, 1961 , and that death occurred at 5:38 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence I. Benson M.D.		DATE SIGNED July 7, 1961	
PHYSICIAN'S NAME (Type) Clarence I. Benson			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 7-11-1961	
22c. NAME OF CEMETERY OR CREMATORY Cokesbury Cemetery		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Patterson & Son		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR DATE JUL 11 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

NAME OF DECEASED John Doe		SEX Male		AGE 45		DATE OF BIRTH Jan 15 1877	
PLACE OF BIRTH Maryland		OCCUPATION Farmer		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
RESIDENCE 123 Main St, Baltimore, Md.		DATE OF DEATH Dec 10 1922		HOURS OF DEATH 10:00 AM		PLACE OF DEATH Home	
NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF FUNERAL HOME None		NAME OF BURIAL PLACE None		DATE OF BURIAL None	
NAME OF NEXT OF KIN Mrs. Jane Doe		NAME OF WITNESS None		NAME OF REGISTRAR None		NAME OF CLERK None	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF FUNERAL HOME None		SIGNATURE OF BURIAL PLACE None		SIGNATURE OF REGISTRAR None	
SIGNATURE OF NEXT OF KIN Jane Doe		SIGNATURE OF WITNESS None		SIGNATURE OF CLERK None		SIGNATURE OF DECEASED None	

RECEIVED
BALTIMORE, MD.
DEC 11 1922

1
FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7860 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07851

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hacks Point		c. LENGTH OF STAY in 1b visiting		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton R.F.D.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dora M. McCommons			4. DATE OF DEATH Month 7 Day 9 Year 19 61				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-1945	9. AGE (In years last birthday) 16 yrs.	IF UNDER 1 YEAR Months 16 Days 16	IF UNDER 24 HRS. Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Girl		10b. KIND OF BUSINESS OR INDUSTRY Student		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME A.P. McCommons			14. MOTHER'S MAIDEN NAME Ethel Jackson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Robert Foard, Chesapeake City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Drowned 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Swimming and went into deep water							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 6 p.m. Month, Day, Year 7 9 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Long Point		20f. (City or town) (County) (State) Hacks Point Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 7-10-61		
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rising Sun, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/12/1961		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or country) (State) Cherry Hill, Maryland	
23. FUNERAL DIRECTOR PIPPIN FUNERAL HOME				ADDRESS Donald M. De Elkton, Md		24a. REC'D BY REGISTRAR JUL 19 61	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

1100

Wash's Point

university

not a function

1399

• **Chl**

232

270-022

3

3-5-5-3

25

10

2

5

2001-2002

104

U.S.U

Rebel Jackson

COMPANY, S.A.

Robert Ford, Cheapside City Rd.

50

Drums

Swimming and went into deep water

10 2 7

X - Long Point

Hacks Point Cecil

32

10. 10.10.10

5-10-21

подроб. С.Я.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville, Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Aikin Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jane Middle Watson Last McGuire		4. DATE OF DEATH Month July Day 11 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-3-1882
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 11 Hours 0 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		12. KIND OF BUSINESS OR INDUSTRY Own Home	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? U S A	
15. FATHER'S NAME Henry Watson		16. MOTHER'S MAIDEN NAME Laura Patterson	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO. None	
19. INFORMANT Howard McGuire, Liberty Grove, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 422.1 DUE TO Mild diabetes mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis Generalized DUE TO (c) 10 yrs. INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 3, 1958 to July 11, 1961 , that I last saw the deceased alive on July 10, 1961 , and that death occurred at 9:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE G.H. Richards Jr.		ADDRESS (Street, city or town, state) DATE SIGNED Port Deposit, Md. 7/11/61	
PHYSICIAN'S NAME (Type) G.H. Richards Jr.			
22a. BURIAL, CREMATION, or other disposition (Specify) Buried		22b. DATE THEREOF 7-14-1961	
22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR DATE JUL 13 '61		24b. REGISTRAR'S SIGNATURE Charles S. Kenna	

CERTIFICATE OF DEATH

1961

M

1. NAME OF DECEASED JAMES WATSON		2. DATE OF DEATH JULY 11, 1961	
3. PLACE OF DEATH Baltimore, Maryland		4. COUNTY Baltimore	
5. SEX Male		6. AGE 42	
7. OCCUPATION None		8. MARITAL STATUS Married	
9. CAUSE OF DEATH None		10. MANNER OF DEATH Natural	
11. SIGNATURE OF PHYSICIAN J. W. Watson		12. SIGNATURE OF DEATH REGISTRAR J. W. Watson	
13. SIGNATURE OF WITNESS J. W. Watson		14. SIGNATURE OF WITNESS J. W. Watson	
15. SIGNATURE OF WITNESS J. W. Watson		16. SIGNATURE OF WITNESS J. W. Watson	
17. SIGNATURE OF WITNESS J. W. Watson		18. SIGNATURE OF WITNESS J. W. Watson	
19. SIGNATURE OF WITNESS J. W. Watson		20. SIGNATURE OF WITNESS J. W. Watson	
21. SIGNATURE OF WITNESS J. W. Watson		22. SIGNATURE OF WITNESS J. W. Watson	
23. SIGNATURE OF WITNESS J. W. Watson		24. SIGNATURE OF WITNESS J. W. Watson	
25. SIGNATURE OF WITNESS J. W. Watson		26. SIGNATURE OF WITNESS J. W. Watson	
27. SIGNATURE OF WITNESS J. W. Watson		28. SIGNATURE OF WITNESS J. W. Watson	
29. SIGNATURE OF WITNESS J. W. Watson		30. SIGNATURE OF WITNESS J. W. Watson	
31. SIGNATURE OF WITNESS J. W. Watson		32. SIGNATURE OF WITNESS J. W. Watson	
33. SIGNATURE OF WITNESS J. W. Watson		34. SIGNATURE OF WITNESS J. W. Watson	
35. SIGNATURE OF WITNESS J. W. Watson		36. SIGNATURE OF WITNESS J. W. Watson	
37. SIGNATURE OF WITNESS J. W. Watson		38. SIGNATURE OF WITNESS J. W. Watson	
39. SIGNATURE OF WITNESS J. W. Watson		40. SIGNATURE OF WITNESS J. W. Watson	
41. SIGNATURE OF WITNESS J. W. Watson		42. SIGNATURE OF WITNESS J. W. Watson	
43. SIGNATURE OF WITNESS J. W. Watson		44. SIGNATURE OF WITNESS J. W. Watson	
45. SIGNATURE OF WITNESS J. W. Watson		46. SIGNATURE OF WITNESS J. W. Watson	
47. SIGNATURE OF WITNESS J. W. Watson		48. SIGNATURE OF WITNESS J. W. Watson	
49. SIGNATURE OF WITNESS J. W. Watson		50. SIGNATURE OF WITNESS J. W. Watson	
51. SIGNATURE OF WITNESS J. W. Watson		52. SIGNATURE OF WITNESS J. W. Watson	
53. SIGNATURE OF WITNESS J. W. Watson		54. SIGNATURE OF WITNESS J. W. Watson	
55. SIGNATURE OF WITNESS J. W. Watson		56. SIGNATURE OF WITNESS J. W. Watson	
57. SIGNATURE OF WITNESS J. W. Watson		58. SIGNATURE OF WITNESS J. W. Watson	
59. SIGNATURE OF WITNESS J. W. Watson		60. SIGNATURE OF WITNESS J. W. Watson	
61. SIGNATURE OF WITNESS J. W. Watson		62. SIGNATURE OF WITNESS J. W. Watson	
63. SIGNATURE OF WITNESS J. W. Watson		64. SIGNATURE OF WITNESS J. W. Watson	
65. SIGNATURE OF WITNESS J. W. Watson		66. SIGNATURE OF WITNESS J. W. Watson	
67. SIGNATURE OF WITNESS J. W. Watson		68. SIGNATURE OF WITNESS J. W. Watson	
69. SIGNATURE OF WITNESS J. W. Watson		70. SIGNATURE OF WITNESS J. W. Watson	
71. SIGNATURE OF WITNESS J. W. Watson		72. SIGNATURE OF WITNESS J. W. Watson	
73. SIGNATURE OF WITNESS J. W. Watson		74. SIGNATURE OF WITNESS J. W. Watson	
75. SIGNATURE OF WITNESS J. W. Watson		76. SIGNATURE OF WITNESS J. W. Watson	
77. SIGNATURE OF WITNESS J. W. Watson		78. SIGNATURE OF WITNESS J. W. Watson	
79. SIGNATURE OF WITNESS J. W. Watson		80. SIGNATURE OF WITNESS J. W. Watson	
81. SIGNATURE OF WITNESS J. W. Watson		82. SIGNATURE OF WITNESS J. W. Watson	
83. SIGNATURE OF WITNESS J. W. Watson		84. SIGNATURE OF WITNESS J. W. Watson	
85. SIGNATURE OF WITNESS J. W. Watson		86. SIGNATURE OF WITNESS J. W. Watson	
87. SIGNATURE OF WITNESS J. W. Watson		88. SIGNATURE OF WITNESS J. W. Watson	
89. SIGNATURE OF WITNESS J. W. Watson		90. SIGNATURE OF WITNESS J. W. Watson	
91. SIGNATURE OF WITNESS J. W. Watson		92. SIGNATURE OF WITNESS J. W. Watson	
93. SIGNATURE OF WITNESS J. W. Watson		94. SIGNATURE OF WITNESS J. W. Watson	
95. SIGNATURE OF WITNESS J. W. Watson		96. SIGNATURE OF WITNESS J. W. Watson	
97. SIGNATURE OF WITNESS J. W. Watson		98. SIGNATURE OF WITNESS J. W. Watson	
99. SIGNATURE OF WITNESS J. W. Watson		100. SIGNATURE OF WITNESS J. W. Watson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
M
I

7862

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07853

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY None	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VA Hospital		d. STREET ADDRESS 1708 A Common Wealth Avenue	
3. NAME OF DECEASED (Type or print) Samuel A. Moss Jr.		4. DATE OF DEATH 7-2-61 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-17
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months 6 Days 26	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Prince William - Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel A. Moss Sr.		14. MOTHER'S MAIDEN NAME Lottie Perkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT VA Records - VAH Perry Point, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis due to extravasated contents DUE TO of viscera Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of duodenal ulcer DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 11 days unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) this hospital attended the deceased from 6-9-61 to 7-2-61, and that death occurred at 1:00 a.m. from the causes and on the date stated above.		22b. DATE SIGNED 7-3-61	
22a. SIGNATURE A. L. Mooney M.D.		22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, Asst. Clinical Pathologist, V.A. Hospital, Perry Point, Md.	
22d. ADDRESS		22e. REC'D BY REGISTRAR	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 7/5/1961	
23c. NAME OF CEMETERY OR CREMATORY Arlington		23d. LOCATION (City, town or county) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		25b. REGISTRAR'S SIGNATURE	

(M)

(I)

Case 11

Ferry Point

VA Hospital

Home

Virginia

Alexandria

23 days

1708 A Common Wealth Avenue

Samuel A.

X

White

Male

Bookkeeper

Loss 17.

7-2-51

12-8-17

43 5 28

France William - Va.

U. S. A.

Lottie Perkins

Samuel A. Jones Jr.

Unit.

SW 11

Yes

VA Records - VA Ferry Point, Maryland

11 days

Portion due to extraneous contents

of viscera

rupture of abdominal aorta

Unknown

VA

8-9-51

7-2-51

1:00 a.m.

XXXXXXXXXXXXXXXXXXXX

Handwritten signature
A. I. ROONEY, M.D., Clinical Pathologist, V.A. Hospital, Ferry Point, Md.

Barrow

Washington, Va.

Handwritten notes:
11/27/54
11/28/54
11/29/54
11/30/54
12/1/54
12/2/54
12/3/54
12/4/54
12/5/54
12/6/54
12/7/54
12/8/54
12/9/54
12/10/54
12/11/54
12/12/54
12/13/54
12/14/54
12/15/54
12/16/54
12/17/54
12/18/54
12/19/54
12/20/54
12/21/54
12/22/54
12/23/54
12/24/54
12/25/54
12/26/54
12/27/54
12/28/54
12/29/54
12/30/54
1/1/55
1/2/55
1/3/55
1/4/55
1/5/55
1/6/55
1/7/55
1/8/55
1/9/55
1/10/55
1/11/55
1/12/55
1/13/55
1/14/55
1/15/55
1/16/55
1/17/55
1/18/55
1/19/55
1/20/55
1/21/55
1/22/55
1/23/55
1/24/55
1/25/55
1/26/55
1/27/55
1/28/55
1/29/55
1/30/55
2/1/55
2/2/55
2/3/55
2/4/55
2/5/55
2/6/55
2/7/55
2/8/55
2/9/55
2/10/55
2/11/55
2/12/55
2/13/55
2/14/55
2/15/55
2/16/55
2/17/55
2/18/55
2/19/55
2/20/55
2/21/55
2/22/55
2/23/55
2/24/55
2/25/55
2/26/55
2/27/55
2/28/55
2/29/55
2/30/55
3/1/55
3/2/55
3/3/55
3/4/55
3/5/55
3/6/55
3/7/55
3/8/55
3/9/55
3/10/55
3/11/55
3/12/55
3/13/55
3/14/55
3/15/55
3/16/55
3/17/55
3/18/55
3/19/55
3/20/55
3/21/55
3/22/55
3/23/55
3/24/55
3/25/55
3/26/55
3/27/55
3/28/55
3/29/55
3/30/55
3/31/55
4/1/55
4/2/55
4/3/55
4/4/55
4/5/55
4/6/55
4/7/55
4/8/55
4/9/55
4/10/55
4/11/55
4/12/55
4/13/55
4/14/55
4/15/55
4/16/55
4/17/55
4/18/55
4/19/55
4/20/55
4/21/55
4/22/55
4/23/55
4/24/55
4/25/55
4/26/55
4/27/55
4/28/55
4/29/55
4/30/55
5/1/55
5/2/55
5/3/55
5/4/55
5/5/55
5/6/55
5/7/55
5/8/55
5/9/55
5/10/55
5/11/55
5/12/55
5/13/55
5/14/55
5/15/55
5/16/55
5/17/55
5/18/55
5/19/55
5/20/55
5/21/55
5/22/55
5/23/55
5/24/55
5/25/55
5/26/55
5/27/55
5/28/55
5/29/55
5/30/55
5/31/55
6/1/55
6/2/55
6/3/55
6/4/55
6/5/55
6/6/55
6/7/55
6/8/55
6/9/55
6/10/55
6/11/55
6/12/55
6/13/55
6/14/55
6/15/55
6/16/55
6/17/55
6/18/55
6/19/55
6/20/55
6/21/55
6/22/55
6/23/55
6/24/55
6/25/55
6/26/55
6/27/55
6/28/55
6/29/55
6/30/55
7/1/55
7/2/55
7/3/55
7/4/55
7/5/55
7/6/55
7/7/55
7/8/55
7/9/55
7/10/55
7/11/55
7/12/55
7/13/55
7/14/55
7/15/55
7/16/55
7/17/55
7/18/55
7/19/55
7/20/55
7/21/55
7/22/55
7/23/55
7/24/55
7/25/55
7/26/55
7/27/55
7/28/55
7/29/55
7/30/55
7/31/55
8/1/55
8/2/55
8/3/55
8/4/55
8/5/55
8/6/55
8/7/55
8/8/55
8/9/55
8/10/55
8/11/55
8/12/55
8/13/55
8/14/55
8/15/55
8/16/55
8/17/55
8/18/55
8/19/55
8/20/55
8/21/55
8/22/55
8/23/55
8/24/55
8/25/55
8/26/55
8/27/55
8/28/55
8/29/55
8/30/55
8/31/55
9/1/55
9/2/55
9/3/55
9/4/55
9/5/55
9/6/55
9/7/55
9/8/55
9/9/55
9/10/55
9/11/55
9/12/55
9/13/55
9/14/55
9/15/55
9/16/55
9/17/55
9/18/55
9/19/55
9/20/55
9/21/55
9/22/55
9/23/55
9/24/55
9/25/55
9/26/55
9/27/55
9/28/55
9/29/55
9/30/55
10/1/55
10/2/55
10/3/55
10/4/55
10/5/55
10/6/55
10/7/55
10/8/55
10/9/55
10/10/55
10/11/55
10/12/55
10/13/55
10/14/55
10/15/55
10/16/55
10/17/55
10/18/55
10/19/55
10/20/55
10/21/55
10/22/55
10/23/55
10/24/55
10/25/55
10/26/55
10/27/55
10/28/55
10/29/55
10/30/55
10/31/55
11/1/55
11/2/55
11/3/55
11/4/55
11/5/55
11/6/55
11/7/55
11/8/55
11/9/55
11/10/55
11/11/55
11/12/55
11/13/55
11/14/55
11/15/55
11/16/55
11/17/55
11/18/55
11/19/55
11/20/55
11/21/55
11/22/55
11/23/55
11/24/55
11/25/55
11/26/55
11/27/55
11/28/55
11/29/55
11/30/55
12/1/55
12/2/55
12/3/55
12/4/55
12/5/55
12/6/55
12/7/55
12/8/55
12/9/55
12/10/55
12/11/55
12/12/55
12/13/55
12/14/55
12/15/55
12/16/55
12/17/55
12/18/55
12/19/55
12/20/55
12/21/55
12/22/55
12/23/55
12/24/55
12/25/55
12/26/55
12/27/55
12/28/55
12/29/55
12/30/55
12/31/55

7863

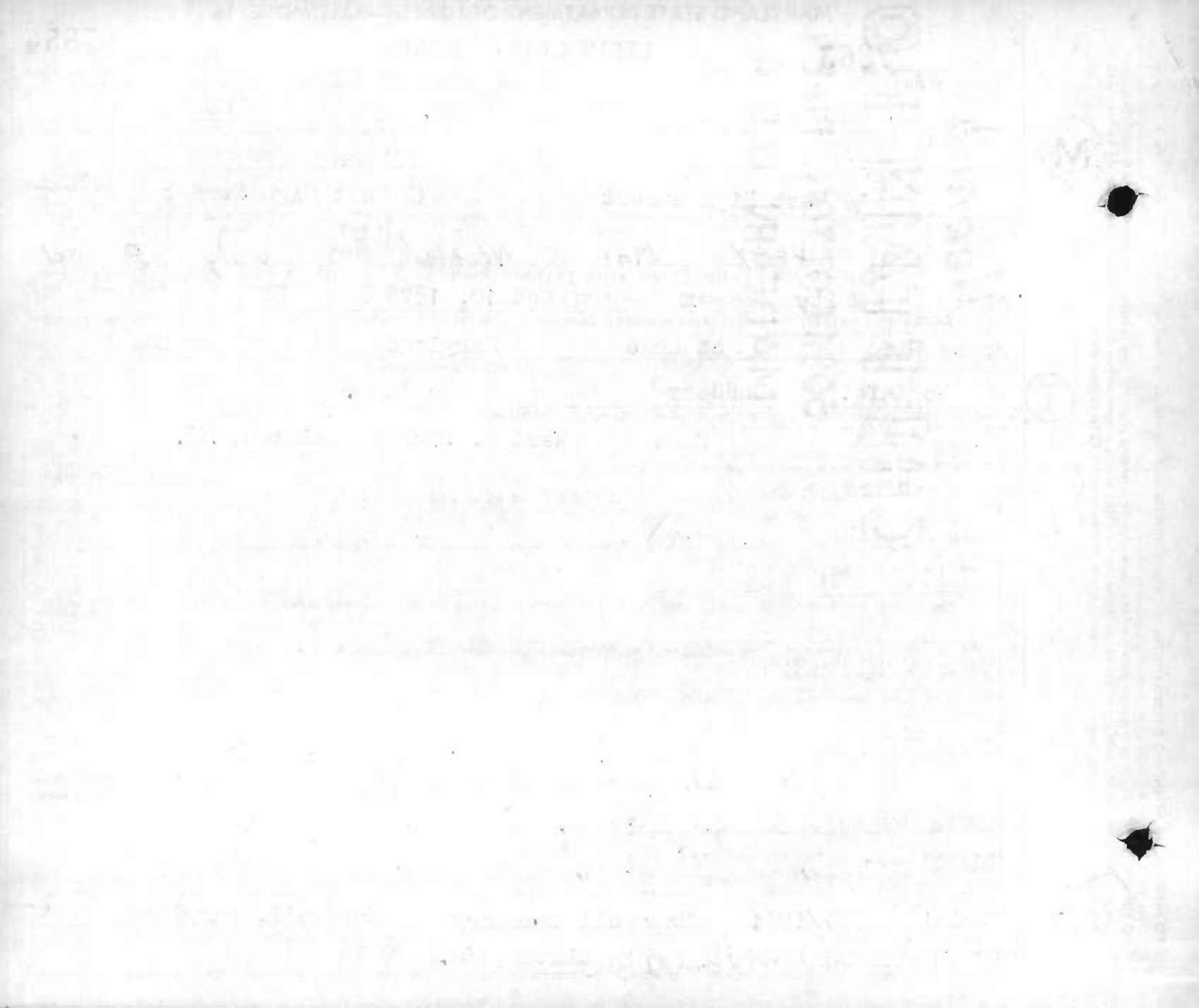
CERTIFICATE OF DEATH

07854

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>236 West High Street</u>				d. STREET ADDRESS <u>236 West High Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Lacy</u> Middle <u>May</u> Last <u>Nickle</u>				4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 10, 1878</u>	
9. AGE (In years lost birthday) <u>82</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>			
13. FATHER'S NAME <u>No Info.</u>				14. MOTHER'S MAIDEN NAME <u>No Info.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Ward B. Nickle</u>				Address <u>Elkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>60</u> , to <u>July 3</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 3</u> , 19 <u>61</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Tillman D. Johnson</u> M.D.				ADDRESS (Street, city or town, state) <u>103 Singlerly Ave</u>			
PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson</u>				DATE SIGNED <u>Elkton Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/7/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hopewell, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u> ADDRESS <u>Elkton, Md.</u>				24a. REC'D BY REGISTRAR <u>JUL 10 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7864 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07855											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b Less than 24 hrs.							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS Main				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last OLIVER G. PARTHREE				4. DATE OF DEATH Month Day Year July 14 1961							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 4-1-06		9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days 12 X - 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY Trucker				11. BIRTHPLACE (State or foreign country) Delta, Pennsylvania			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John M. Parthree				14. MOTHER'S MAIDEN NAME Cecelia Downey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-II				16. SOCIAL SECURITY NO. unknown				17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Hemorrhage, subdural, right. 12 hours 900.00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2. Fractures of the calvarium, multiple. 12 hours DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down flight of stairs, approximately 10 steps.							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3:30 xxx July 13 1961				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			
				20f. (City or town) Whiteford				(State) Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE R. C. DODSON				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 7-14-61			
EXAMINER'S NAME (Type) R. C. DODSON				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) Rising Sun, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-17-1961				22c. NAME OF CEMETERY OR CREMATORY Mt. Nebo			
								22d. LOCATION (City, town, or country) Delta, Pa.			
23. FUNERAL DIRECTOR Harkins Funeral Home, Delta, Pa.				24a. REC'D BY REGISTRAR DATE JUL 18 '61				24b. REGISTRAR'S SIGNATURE Arthur L. Harkins			

THE STATE
OF NEW YORK



W. C. DORRIS

3:30 PM JULY 1961 Home Whiteford Maryland

Tell down right of state, approximately 10 acres.

2. Fracture of the calcaneus, right.

1. Hemorrhage, subdural, right.

Yes 1-11 Unknown Hospital records, Vol. Perry Jones, Md.

John E. Kerkner Cecelia Kerkner

Trucker Pennsylvania

Male Five 1-1-10

Silver

See on information brought

Very fine

Wood

1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7865

CERTIFICATE OF DEATH

Reg. Dist. No.

07856

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton Rural		c. LENGTH OF STAY IN lb 6 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton Rural	
		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mattie Middle Adams Last Pugh		4. DATE OF DEATH Month July Day 12 Year 19 61	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2-28-1895
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jackson Adams		14. MOTHER'S MAIDEN NAME Nancy Denny	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
INFORMANT Roger Pugh		Address Elkton Rd Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcoma of the chest wall with 197.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pulmonary metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized arteriosclerosis and malnutrition 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 9 , 19 61 , to July 12 , 19 61 that I last saw the deceased alive on July 11 , 19 61 , and that death occurred at 4:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 7/12/61 ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D. Elkton Maryland PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15, 1961	
22c. NAME OF CEMETERY OR CREMATORY Lansing Ashe Co., N.C.		22d. LOCATION (City, town, or county) (State) Lansing	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		24a. REC'D BY REGISTRAR JUL 17 '61	
ADDRESS North East Md		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07857

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fredricktown Home		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fredricktown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Howard Reese		4. DATE OF DEATH Month July Day 13 Year 1961	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 30, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor		11. BIRTHPLACE (County & State, or foreign country) Md.	
13. FATHER'S NAME Howard Reese Sr.		14. MOTHER'S MAIDEN NAME Annie Gaddys	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Rosie Henry, Henderson, Md. R.D.1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Acute congestive failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic heart disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). Acute Bronchial asthma		INTERVAL BETWEEN ONSET AND DEATH 10 min. years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 12 , 19 61 to July 13 , 19 61 , that (I) (we) last saw the deceased alive on July 13 , 19 61 , and that death occurred at 3 PM , from the causes and on the date stated above.			
22a. SIGNATURE Wallace Obenshain		22b. DATE SIGNED 14 July 61	
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.		22d. ADDRESS Cecilton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July, 16, 1961	23c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery	23d. LOCATION (City, town or county) (State) Cecil Co; Md.
24. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Mellington, Md.		25a. REC'D BY REGISTRAR DATE JUL 18 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

(M)

1896

Small

Small

Small

Production

Production

Production

Small

Small

Colored

Colored

Small

January 20, 1900

Small

Small

Small

Small

Small

Small

Small

Small

Small

Small

Small

Small

Small

Small

Small

Small

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars names to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07853

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>1 Day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Naomi S.</u> Middle <u>Ross.</u> Last <u></u>		4. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 4 1912</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles M. Swartz</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Conley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>XXXXXXXX</u>		16. SOCIAL SECURITY NO. <u>XXXXXXXX</u>	
17. INFORMANT <u>Pemberton J. Ross</u>		Address <u>Rd # 4, Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhagic Pericarditis</u> DUE TO (b) <u>Pneumonectomy Of Right Lung</u> DUE TO (c) <u>Carcinoma Of Lung</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u> <u>3 Months</u> <u>4 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/23/1961</u> to <u>7/24/1961</u> , that I lost sowing the deceased olive on <u>7/24/1961</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James L. Johnson</u>		ADDRESS (Street, city or town, state) <u>245 East High Street</u> DATE SIGNED <u>7/26/61</u>	
PHYSICIAN'S NAME (Type) <u>James L. Johnson M. D.</u>		<u>Elkton, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/27/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Elkton, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter du Bose</u>		ADDRESS <u>Elkton, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 31 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

7868

CERTIFICATE OF DEATH

Reg. Dist. No. 07859

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 8 months			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Elkton,				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Kathryn First H. Middle Scarborough Last				4. DATE OF DEATH Month July Day 19 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 4, 1873	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Washington Hall				14. MOTHER'S MAIDEN NAME Sarah Jane Steele			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No			
17. INFORMANT Address Stanley R. Scarborough, R. D. 3, Elkton							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Bronchopneumonia (b) Congestive Heart Failure (c) AHD. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephrosclerosis INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year 5 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1953 to 7/9, 1961, that I last saw the deceased alive on 7/17, 1961, and that death occurred at 4:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7/24/61							
ACTUAL SIGNATURE Peter Stavrakis, M.D.							
PHYSICIAN'S NAME (Type) Peter Stavrakis, M.D. 154 W. Main St., Elkton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 22, 1961		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or county) Cecil County Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				ADDRESS Elkton, Maryland			
24a. REC'D BY REGISTRAR DATE AUG 1 '61				24b. REGISTRAR'S SIGNATURE Charles S. Kinross			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1888

General and Special

1888

(M)

7869

CERTIFICATE OF DEATH

Reg. Dist. No. 07860

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bert Sexton		4. DATE OF DEATH July 1 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1920
9. AGE (In years lost birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto. mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automotive	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lester F Sexton		14. MOTHER'S MAIDEN NAME Btta Weidner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 232-28-8686	
INFORMANT Mrs. Lillie R. Sexton		Address Charlestown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Branchopneumonia Organism Undet (b) And Myocardial Infarction (c) And Acute Fibrinous Pericarditis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 days 10 days 8 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 26 1961, to July 1, 1961, that I last saw the deceased alive on July 1, 1961, and that death occurred at 11:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Williford Eppes		M.D. July 5, 1961	
PHYSICIAN'S NAME (Type) Williford Eppes		327 E Main St., Newark, Delaware	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-5-1961	22c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens	22d. LOCATION (City, town, or county) (State) Harford County Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant, North East, Md.		24a. REC'D BY REGISTRAR DATE JUL 6 '61	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1903

(M)

(T)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

7870

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07861

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Joppa	
c. LENGTH OF STAY in 1b 15 days		d. STREET ADDRESS Box 537	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Unknown	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle (NMI) (STANKVICH) STANKIE		4. DATE OF DEATH Month July Day 11 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-96
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Stankie		14. MOTHER'S MAIDEN NAME Victoria (?)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. 705-07-2384	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach with metastasis DUE TO (b) 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. VA p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from June 26, 1961 to July 11, 1961 and that death occurred 11:15am from the causes and on the date stated above.			
22a. SIGNATURE B. Rothfeld M.D.		22b. DATE SIGNED 7-11-61	
22c. PHYSICIAN'S NAME (Type) B. ROTHFELD, Acting Chief, Medical Service, VAH, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 14, 1961	
23c. NAME OF CEMETERY OR CREMATORY St. Stephens		23d. LOCATION (City, town or county) (State) Bradshaw, Balto., Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son, Abingdon, Md.		25a. REC'D BY REGISTRAR DATE JUL 17 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

Constitution

10-077 (S)

1100

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2871

07862

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point | | | | c. LENGTH OF STAY IN 1b Less than 24hrs | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) ROBERT C. SUMMERS | | | | 4. DATE OF DEATH Month July Day 21 Year 1961 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7-14-28 | |
| 9. AGE (In years last birthday) 33 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician | | | | 10b. KIND OF BUSINESS OR INDUSTRY unknown | | 11. BIRTHPLACE (State or foreign country) Connecticut | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Carleton Summers | | | | 14. MOTHER'S MAIDEN NAME Evelyn Mealia | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-II | | | | 16. SOCIAL SECURITY NO. 220-24 9030 | | | |
| 17. INFORMANT Address Hospital Records, VAH, Perry Point, Md. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1. Bronchopneumonia, bilateral.
491X DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 2. Abdominal carcinomatosis, primary site Unknown
DUE TO unknown.
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | | 2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE R. C. DODSON | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) R. C. Dodson MD | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| DATE THEREOF 7-24-61 | | | | DATE SIGNED Rising Sun, Md. 7/21/61 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | | 22d. LOCATION (City, town, or country) Baltimore, Md | |
| 23. FUNERAL DIRECTOR Rosedale Funeral Home, 2411 Cheseco Ave. | | | | ADDRESS Baltimore, Md. | | 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE | |
| DATE JUL 24 '61 | | | | C. L. K. K. | | | |

MEDICAL CERTIFICATION

(M)

07882

METACAL EXAMINER'S CERTIFICATE OF DEATH

1911

0001

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7872 CERTIFICATE OF DEATH 07863

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland | | b. COUNTY
— | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point | | c. LENGTH OF STAY IN 1b
7mo. 13days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | 3Y01-4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans administration Hospital | | 3914 Pinkney Road | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
CHARLES LEWIS TOOR | | First Middle Last | | 4. DATE OF DEATH
July 27 1961 | | Month Day Year | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
7-22-97 | |
| 9. AGE (In years last birthday)
64 | | 10. IF UNDER 1 YEAR
Months Days | | 11. IF UNDER 24 HRS.
Hours Min. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Manager | | 10b. KIND OF BUSINESS OR INDUSTRY
Store | | 11. BIRTHPLACE (County & State, or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Simon Toor (deceased) | | 14. MOTHER'S MAIDEN NAME
Ida Sealfon (deceased) | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
WW-1 | | 17. INFORMANT
Address
Hospital Records, VAH, Perry Point, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
443X
DUE TO
Hypertensive cadio - vascular disease
(b)
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
Unk. | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Arteriosclerosis, generalized. Chronic Brain Syndrome | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from December 14, 1960 to July 27, 1961 and that death occurred at 2:58 PM from the causes and on the date stated above. | | 22a. SIGNATURE
Dnia Allahverdi
M.D. | | 22b. DATE SIGNED
7-27-61 | | | |
| 22c. PHYSICIAN'S NAME (Type)
DNIA ALLAHVERDI, M.D. | | 22d. ADDRESS
V.A. Hospital, Perry Point, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
July 28/61 | | 23c. NAME OF CEMETERY OR CREMATORY
Beth Tfiloh | | 23d. LOCATION (City, town or county) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Sol Levenson & Bros. 6010 Reistertown Rd., | | 25a. REC'D BY REGISTRAR
AUG 1 1961 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Evans | | | |

(M)

(I)

Simon, Peter (deceased)

195-07-0021 Hospital Records, Fall, Army Point, Pa.

Hypertensive crisis - vascular disease

Myocardial infarction, Generalized, Chronic, in progress

November 11, 60 July 17

12:00 PM

John J. [Signature]

... Hospital, Army Point, Pa.

... Pa.

... Pa.

Bellevue Hospital & ... Pa.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completed and filled in by the funeral director. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 3 and 4 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|---|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 7873 | | | | | 07864 | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) | | | | |
| a. COUNTY
Cecil | | | | | a. STATE
Maryland | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point | | | | | b. COUNTY
Harford | | | | |
| c. LENGTH OF STAY IN 1b
3 mo. 18 days | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Darlington | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | | | | d. STREET ADDRESS
12 X-2 | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | 4. DATE OF DEATH | | | | |
| First Middle Last
ALVAH S. WHEATON | | | | | Month Day Year
July 5 1961 | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
3-18-91 | | 9. AGE (In years last birthday)
70 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Operator | | 10b. KIND OF BUSINESS OR INDUSTRY
Machine | | 11. BIRTHPLACE (County & State, or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Samuel Wheaton (deceased) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
Yes WW-I | | 16. SOCIAL SECURITY NO.
162-03-4409 | | 17. INFORMANT
Hospital Records, VAH, Perry Point, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5-15 min. | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arrhythmia ventricular
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease
DUE TO (c) unknown | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Arteriosclerosis generalized | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. VA 19
p.m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that XXXXXX attended the deceased from March 17, 1961 to July 5, 1961 and that death occurred 5:20 pm from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
A. L. Mooney | | | | | 22b. DATE SIGNED
7-6-61 | | | | |
| 22c. PHYSICIAN'S NAME (Type)
A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md. | | | | | 22d. ADDRESS
Pennington & Son, Harre de Grace, Md. | | | | |
| 23a. BURIAL CREMATION (REMOVAL) (Specify)
3/10/61 | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City, town or county) (State)
Arlington, Virginia | | 25a. REC'D BY REGISTRAR
JUL 11 '61 | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Pennington & Son, Harre de Grace, Md. | | | | | 25b. REGISTRAR'S SIGNATURE
Carlton S. Thomas | | | | |

873

(M)

Left Point 5 mo. 18 days

Veteran Administration Hospital

White RIVER

White 3-18-51

Operation Machine

General Hanson (deceased) Gary, Indiana (deceased)

Yes 10-1 102-07-2473 Hospital Records, Vol. Perry Point, Md.

Arrhythmia ventricular 5-15 min.

Myocarditis heart disease

Arteriosclerosis generalized

March 17 51 5:20pm

10-6-51

Dr. I. M. MOOREY and Clinical Pathologist, Vol. Perry Point, Md.

Division National Arlington, Virginia

10-6-51